

Exhibit 3: State Mandated Benefits and Potential Inclusion under a Federally Defined EHB

CT General Statutes: Chapter 700c, §	Mandate	Description	EHB Status? (from Mercer)
Health Service Benefit Mandates			
38a-476b	Availability of Psychotropic Drugs	No mental health care benefit provided under state law, with state funds, or to state employees may limit the availability of the most effective psychotropic drugs.	unknown
38a-483c; 38a-513b	Experimental Treatments	Procedures, treatments, or drugs that have completed a Phase III FDA clinical trial. Appeals process expedited for those with a life expectancy of less than two years.	unknown
38a-488a; 38a-514	Mental Illness	Diagnosis and treatment of mental or nervous conditions. Coverage cannot differ from the terms, conditions, or benefits for the diagnosis or treatment of medical, surgical, or other physical health conditions. Requires a policy to cover a residential treatment facility when a physician, psychiatrist, psychologist, or clinical social worker assesses the person and determines that he or she cannot appropriately, safely, or effectively be treated in another setting.	unknown
38a-490; 38a-508; 38a-516; 38a-549	Children - Newborns and Adopted	Injury and sickness, including care and treatment of congenital defects and birth abnormalities, for newborns from birth and for adopted children from legal placement for adoption.	yes
38a-490a; 38a-516a	Birth-to-Three	At least \$6,400 per child annually for medically necessary early intervention services, up to \$19,200 per child over three years.	unknown
38a-490b; 38a-516b	Children's Hearing Aids	Hearing aids for children age 12 and under. Coverage may be limited to \$1,000 within a 24-month period.	unknown
38a-490c; 38a-516c	Craniofacial Disorders	Medically necessary orthodontic processes and appliances for treatment of craniofacial disorders for people age 18 or younger. Coverage is not required for cosmetic surgery.	unknown
38a-490d; 38a-535	Blood lead screening and risk assessment	Every primary care provider giving pediatric care (excluding hospital emergency room) shall conduct lead screening and risk assessment *38a-535 mandates broader preventative pediatric care services, listed below	yes
38a-492i; 38a-516d	Children with Cancer	Coverage for children diagnosed with cancer after December 31, 1999 for neuropsychological testing a physician orders to assess the extent chemotherapy or radiation treatment has caused the child to have cognitive or developmental delays. Insurers cannot require pre-authorization for the tests.	unknown
38a-491a; 38a-517a	Dental Coverage	Medically necessary general anesthesia, nursing, and related hospital services for in-patient, outpatient, or one-day dental services.	unknown
38a-492; 38a-518	Accidental Ingestion or Consumption of Controlled Drugs	Emergency medical care for the accidental ingestion or consumption of controlled drugs. Coverage is subject to a minimum of 30 days inpatient care and a maximum \$500 for outpatient care per calendar year.	unknown
38a-492a; 38a-518a	Hypodermic Needles and Syringes	Hypodermic needles and syringes prescribed by a prescribing practitioner for administering medications.	unknown
38a-492b; 38a-518b	Off-Label Cancer Drugs	If a prescription drug is recognized for treatment of a specific type of cancer, a policy cannot exclude coverage of the drug when it is used for another type of cancer.	unknown
38a-492c; 38a-518c	Protein Modified Food and Specialized Formula	Amino acid modified and low protein modified food products when prescribed for the treatment of inherited metabolic diseases and cystic fibrosis. Medically necessary specialized formula for children up to age 12. Food and formula must be administered under the direction of a physician. Coverage for preparations, food products, and formulas must be on the same basis as coverage for outpatient prescription drugs.	unknown
38a-492d; 38a-518d	Diabetes	Laboratory and diagnostic tests for all types of diabetes. Medically necessary equipment, drugs, and supplies for insulin-dependent, insulin using, gestational, and non-insulin using diabetes.	yes

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38a-492e; 38a-518e		Diabetes Self-Management Training	Outpatient self-management training prescribed by a licensed health care professional. Coverage is subject to the same terms and conditions as other policy benefits.	unknown
38a-492f; 38a-518f		Prescription Drugs Removed from Formulary	A prescription drug that has been removed from the list of covered drugs must be continued if the insured was previously using the drug for the treatment of a chronic illness and it is deemed medically necessary.	unknown
38a-492g; 38a-518g		Prostate Screening	Laboratory and diagnostic tests to screen for prostate cancer for men who are symptomatic, have a family history, or are over 50.	yes
38a-492h; 38a-518h		Lyme Disease Treatment	Lyme disease treatment including not less than 30 days of intravenous antibiotic therapy, 60 days of oral antibiotic therapy, or both, and further treatment if recommended by a rheumatologist, infectious disease specialist, or neurologist.	unknown
38a-492j; 38a-518j		Ostomy Appliances and Supplies	If policy covers ostomy surgery, policy must also cover up to \$1000 per year for medically necessary ostomy-related appliances and supplies.	unknown
38a-492k; 38a-518k		Colorectal Cancer Screening	Colorectal cancer screening. Frequency of screening to be based on recommendations by the American College of Gastroenterology.	yes
38a-492m; 38a-518l		Prescription Eye Drops	Effective January 1, 2010, policies that provide prescription eye drop coverage cannot deny coverage for prescription renewals when (1) the refill is requested by the insured person less than 30 days from either (a) the date the original prescription was given to the insured or (b) the last date the prescription refill was given to the insured, whichever is later, and (2) the prescribing physician indicates on the original prescription that additional quantities are needed and the refill request does not exceed this amount.	unknown
38a-492n; 38a-518m		Epidermolysis Bullosa	Effective January 1, 2010, policies must cover wound care supplies that are medically necessary to treat epidermolysis bullosa (a rare skin disorder) and administered under a physician's direction.	unknown
38a-493; 38a-520		Home Health Care	Home health care, including (1) part-time or intermittent nursing care and home health aide services; (2) physical, occupational, or speech therapy; (3) medical supplies, drugs and medicines; and (4) medical social services. Coverage can be limited to no less than 80 visits per year and, for a terminally ill person, no more than \$200 for medical social services. Coverage can be subject to an annual deductible of up to \$50 and a coinsurance of no less than 75%, except that a high deductible plan used to establish a medical savings account is exempt from the deductible limit.	unknown
38a-496; 38a-524		Occupational Therapy	If policy covers physical therapy, it must provide coverage for occupational therapy.	unknown
38a-498; 38a-525		Ambulance Services	Ambulance service when medically necessary. Payment must be on a direct pay basis where notice of assignment is reflected on the bill.	unknown
38a-498c; 38a-525c		Injured and Under the Influence	Insurance policies prohibited from denying coverage for health care services rendered to an injured insured person if the injury is alleged to have occurred or occurs when the person has an elevated blood alcohol level (0.08% or more) or is under the influence of drugs or alcohol.	unknown

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38a-503; 38a-530	Mammography and Breast Cancer Screening	Baseline mammogram for woman 35 to 39 and one every year for woman 40 and older. Additional coverage must be provided for a comprehensive ultrasound screening of a woman's entire breast(s) if (1) a mammogram shows heterogeneous or dense breast tissue based on BI-RADS or (2) the woman is at increased breast cancer risk because of family history, her prior history, genetic testing, or other indications determined by her physician or advanced-practice nurse. Coverage is subject to any policy provisions applicable to other covered services.	yes
38a-503c; 38a-530c	Minimum Stay for Maternity Care	coverage of a minimum of forty-eight hours of inpatient care for a mother and her newborn infant following a vaginal delivery and a minimum of ninety-six hours of inpatient care for a mother and her newborn infant following a caesarean delivery	yes
38a-503d; 38a-530d.	Mastectomy	Minimum 48-hour hospital stay after mastectomy or lymph node dissection or longer stay if recommended by physician.	unknown
38a-503e; 38a-530e	Contraceptives	If prescription drugs are covered, prescription contraceptives must be covered. An employer or individual may decline contraceptive coverage if it conflicts with religious beliefs.	yes
38a-504a&b; 38a-542a&b	Treatment for Leukemia, Tumors, and Wigs for Chemotherapy Patients	Surgical removal of tumors and treatment of leukemia, including outpatient chemotherapy, reconstructive surgery, non-dental prosthesis, surgical removal of breasts due to tumors, and a wig if prescribed by a licensed oncologist for a patient suffering hair loss from chemotherapy. Annual coverage must be at least \$500 for surgical tumor removal, \$500 for reconstructive surgery, \$500 for outpatient chemotherapy, \$350 for a wig, and \$300 for prosthesis, except for surgical removal of breasts due to tumors, the prosthesis benefit must be at least \$300 for each breast removed.	yes
38a-504c; 38a-542c	Breast Reconstruction after Mastectomy	Reconstructive surgery on non-diseased breast for symmetrical appearance. Coverage is subject to the same terms and conditions as other benefits under the policy.	unknown
38a-504a–g; 38a-542a–g	Cancer Clinical Trials	Routine patient costs relating to cancer clinical trials. Out-of-network hospitalization paid as in-network benefit if services are not available in network. Such trials must have peer-reviewed protocols approved by one of several federal organizations.	unknown
38a-504; 38a-542	Oral Chemotherapy	Effective January 1, 2011, policies that cover intravenously and orally administered anticancer medications must cover the orally administered medication on at least as favorable a basis as the intravenously administered medication.	unknown
38a-509; 38a-536	Infertility	Medically necessary costs of diagnosing and treating infertility.	unknown
38a-488b; 38a-514b	Autism Spectrum Disorders	Effective January 1, 2010, policies must cover the diagnosis and treatment of autism spectrum disorders, including 1 behavioral therapy for a child age 14 or younger and 2 certain prescription drugs and psychiatric and psychological services. A policy can limit coverage for behavioral therapy to \$50,000 a year for a child age eight or younger, \$35,000 for a child age nine to 12, and \$25,000 for a 13-or 14-year-old.	unknown
38a-523*	Comprehensive Rehabilitation Services	Group health insurance must offer coverage for comprehensive rehabilitation services, including 1 physician services, physical and occupational therapy, nursing care, psychological and audiological services, and speech therapy; 2 social services provided by a social worker; 3 respiratory therapy; 4 prescription drugs and medicines; 5 prosthetic and orthotic devices and; 6 other supplies and services prescribed by a doctor.	unknown

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38a-533*	Alcoholism		Expenses incurred in connection with medical complications of alcoholism such as cirrhosis of the liver, gastrointestinal bleeding, pneumonia, and delirium tremens.	unknown
38a-535*	Preventive Pediatric Care		Preventive pediatric care at the following intervals 1 every 2 months from birth to 6 months, 2 every 3 months from 9 to 18 months, and 3 annually from 2 to 6 years of age. Coverage is subject to any policy provisions that apply to other services covered under the policy.	yes
38a-542a*	Breast Implant Removal		Medically necessary removal of breast implants implanted on or before July 1, 1994. Annual coverage must be at least \$1,000.	unknown
Provider Mandates and/or Policy Mandates				
38a-476b1; 38a-476b2; 38a-476g	Preexisting Condition Coverage		May not impose preexisting condition exclusion beyond 12 months after effective date of coverage, and exclusion may relate only to conditions for which medical advice, diagnosis, care, or treatment was recommended or received six months before the policy's effective date.	-
38a-482; 38a-497; 38a-554	Children		Under individual health insurance policies, coverage continues at least until the policy anniversary date on or after the date the child 1 marries; 2 ends Connecticut residency, unless he or she is a under age 19 or b a full-time student at an accredited college; 3 gets coverage under his or her employer's group health plan; or 4 turns age 26. Group comprehensive health care plans must 1 extend coverage eligibility to unmarried children under age 26 and 2 offer continuation coverage to the end of the month in which the child meets the criteria for losing coverage under an individual policy.	-
38a-489; 38a-515; 38a-554	Children - Mentally or Physically Handicapped		After passing dependent status age and coverage would otherwise end, coverage must continue if child is both mentally or physically handicapped and dependent upon insured for support.	unknown
38a-497; 38a-554	Stepchildren		Effective June 18, 2009, policies must cover stepchildren on the same basis as biological children.	-
38a-501**	Long-Term Care Policy – Elimination Period		Requires an elimination period i.e., a waiting period after the onset of the injury, illness, or function loss during which no benefits are payable that is 1 up to 100 days of confinement or 2 between 100 days and two years of confinement if an irrevocable trust is in place that is estimated to be sufficient to cover the person's confinement costs during this period. Sets requirements for the trust.	-
38a-511; 38a-550	Copays for Imaging Services MRIs, CAT scans, and PET scans		Limits copays for MRIs and CAT scans to 1 \$375 for all such services annually and 2 \$75 for each one. Limits copays for PET scans to 1 \$400 for all such scans annually and 2 \$100 for each one. Limits not applicable 1 if the ordering physician performs the service or is in the same practice group as the one who does and 2 to high deductible health plans designed to be compatible with federally qualified Health Savings Accounts.	-
38a-492i; 38a-518i	Pain Management		Access to a pain management specialist and coverage for pain treatment ordered by such specialist.	unknown
38a-498b; 38a-525b	Mobile Field Hospitals		Benefits for isolation care and emergency services provided by mobile field hospitals, previously called critical access hospitals. Such benefits are subject to any policy provisions that apply to other covered services. The rates a policy pays must be equal to the rates Medicaid pays, as determined by the Department of Social Services.	unknown

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38a-499; 38a-526	Physician assistants and certain nurses.	Mandatory coverage for the services of physician assistants, certified nurse practitioners, certified psychiatric-mental health clinical nurse specialists and certified nurse-midwives if such services are within the individual's area of professional competence as established by education and licensure or certification and are currently reimbursed when rendered by any other licensed health care provider.	unknown
38a-503b	Obstetrician-Gynecologist; Pap Smear	Direct access to participating in-network ob-gyn for gynecological examination, pregnancy care, and primary and preventive obstetric and gynecologic services required as result of a gynecological examination or condition includes pap smear. Female enrollees may also designate participating ob-gyn or other doctor as primary care provider.	unknown
38a-507; 38a-534	Chiropractic Services	Cover chiropractor services to same extent as coverage for a physician.	unknown
38a-502; 38a-529	Veterans Home	No individual health insurance policy delivered may exclude coverage for services provided by the Veterans' Home.	unknown
38a-498a; 38a-525a	911 Calls	Cannot require preauthorization for 911 calls.	-
38a-511; 38a-550	Copays for Imaging Services MRIs, CAT scans, and PET scans	Limits copays for MRIs and CAT scans to 1 \$375 for all such services annually and 2 \$75 for each one. Limits copays for PET scans to 1 \$400 for all such scans annually and 2 \$100 for each one. Limits not applicable 1 if the ordering physician performs the service or is in the same practice group as the one who does and 2 to high deductible health plans designed to be compatible with federally qualified Health Savings Accounts.	-

DOLLAR LIMITS ON CERTAIN BENEFITS: Per the Connecticut Insurance Department CID With the exception of the Autism Spectrum Disorder ASD mandate, effective in Sept. of 2010 all dollar limits were removed from those mandated benefits which specified such e.g. hearing aids - \$1,000, ostomy supplies-\$1,000 these benefits although unlimited in terms of dollars continue to be reviewed for Medical Necessity. With respect to ASD, the dollar maximums e.g. behavioral therapy to \$50,000 a year for a child age eight or younger will be removed effective January 1, 2014. The ASD services are viewed are separately and not clearly included in any EHB category including Mental Health therefore the dollar limits continue to apply.

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